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MANUAL FOR THE PSYCHODIAGNOSTIC BLANK[1]

A Guide for Diagnostic Interviewing in Psychological Clinic Work

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INTRODUCTORY NOTE

This manual is written with two specific purposes in mind: first, for clinic and classroom use at Indiana University where the *Psychodiagnostic Blank* (34)[2] is used as a guide for diagnostic interviewing, and second, to fill the need for a description of the Fourth (1939) Edition of the Blank in response to the demands of users in schools and clinics elsewhere. Appropriate to these purposes, the writer has attempted something more than a sheer description of the mechanical use of the Blank by trying to indicate the reasons for securing the information suggested by its rubrics and by including enough informational materials for orientational purposes. Although the scope of this manual as such necessarily limits the amount of these extensions, references to the literature in general and to C. M. Louttit's *Clinical Psychology* (33) in particular are interspersed in the text for those who may want them.

Both the *Psychodiagnostic Blank* and this manual are based upon the conception that the method of psychoclinical investigation is essentially one of interviewing, and that, in the main, diagnostic procedures fall into two general types of interview techniques: (1) standardized interview-tests such as the Binet and other psychometric tests; and (2) unstandardized interviewing which may vary from casual conversations with the child and the spontaneous

[1]Publications I.U. Psychological Clinics Ser. II, No. 24.

[2]A twelve page blank which may be secured from the Psychological Corporation at 522 Fifth Ave., New York City, or from the Principia Press, Indiana University, Bloomington, Ind., at six cents each in quan-

tities of less than 100 and five cents each for a hundred or more.
complaints of informants to more systematic questions and answers. Both are directed towards the same end: namely, of trying to discover in a psychodiagnostic sense "Who is this child and what are his problems?" With few exceptions, neither the standardized techniques by themselves nor unstandardized interviewing alone will satisfy the requirements of good clinical practice. Both are required in the great majority of cases.

In good clinical practice, both types of interview techniques are employed to obtain a behavior picture of the child and his problems in two dimensions. The first, or cross-sectional dimension, is secured by the clinician directly from his own observation of the child's behavior by means of both psychometric tests and unstandardized interviews and indirectly from informants' descriptions of the child's behavior as it is at the time, in the home, school and elsewhere. The second, or longitudinal dimension, is concerned with the historical antecedents of the child's behavior. Unlike the cross-sectional, there are no standardized interview techniques for getting at the longitudinal or developmental dimensions of the child's behavior because of the myriad complexity of his reactional biography (27, Chs. III-VII). Rather, the clinician has to rely upon parents and other sources for information about the child's behavior development. Each of these two dimensions is of the utmost importance in sound diagnostic work. The one is a necessary complement of the other. Together, they constitute an objective approach that is in harmony with the highest standards of clinical practice (35).

It was upon these assumptions that Professor Louttit, with the help of Mr. W. B. Waskom, devised in 1933 the first edition of the *Psychodiagnostic Blank* for use in the Indiana University Psychological Clinics. Since then, the Blank has been modified through constant use in our clinics and has been issued in a fourth edition. In 1937 and again in 1939, the writer collaborated with Professor Louttit in making extensive revisions of the second and third editions respectively. Because it was felt that the fourth edition had attained a fairly high degree of stability in desirable content and arrangement, the present time seemed opportune to publish this manual for it.

Section I Identifying Data

Because of additional contacts, requests for information by other agencies and the research possibilities at a subsequent date, case records are often of as much or more value years later than when first secured. Through inadequate identification, case records may lose their research value and are sometimes lost in files or confused with other case records. For these reasons, the interviewer should, by all means, avoid the temptation to be careless and to regard the recording of adequate identifying data as a somewhat unnecessary chore in the immediate interviewing situation. The identifying data for every case should be as complete as possible and legibly written in ink in definite anticipation of their later use. They should be routinely recorded in the very first part of the interview rather than later when they may be forgotten. We have found all the items described below necessary for adequate identification of a case.

1. *Name.* Record the full name to avoid possible confusion in filing the case. Nicknames may also be recorded but they should never be used in place of the real name. If the child's family name differs from that of the person given in item 10, explain under the latter heading. Care must be taken with spelling and legibility of writing.

2. *Sex.* For the sake of brevity use the abbreviations M for male and F for female.

3. *Race.* This heading is intended to cover both race and nationality. The abbreviations C and W may be used for colored and white respectively. Again, a boy of Italian parents should be recorded as W-Ital, because the record of his birthplace will be sufficient indication of his political citizenship. In case of individuals born abroad, but naturalized, a record should be made elsewhere of the date and place of naturalization.

4. *C. A.* The chronological age should be given in years and months as of the time when first examined. It must correspond to the difference between the birthdate (item 6) and the date of examination (item 13). One should always check C. A. computations at least once.

5. *Address.* The address should include the street name and number as well as the city and, where desirable, the county. In case

children live on rural routes, the exact location should be indicated, e.g., Box 10, R.R. No. 4, Smith Road, two miles south of Columbus.

6. *Birthdate.* The exact birthdate should be recorded. This may be secured from the parents or school records but, in case of the slightest doubt, an attempt should be made to check with the vital records of the county of birth. When a birthdate is *verified,* it should be so noted by a check in the appropriate place. Doubt may arise from inconsistency in the informant's statements concerning the child's age, present grade placement and age when first started to school; or, sometimes from the child's physical size and appearance, his performance on standardized tests and his general behavior.

7. *Birthplace.* The exact place of birth should be secured, or at least, the county or incorporated village, so that the vital records can be checked. In case of foreign birth, the name of the community should also be included if possible.

8. *School.* The name or number of the school and its type should be designated, e.g., Stokes Junior High; No. 5, elementary; Adams, private; St. Ann, parochial, etc.

9. *Grade.* Record the grade the child is in when seen, except when a child has just been promoted; then use the grade promoted to. Where he has quit school, record the grade he was last in and note, for example, quit in 6th grade, or, finished the 6th grade.

10. *Parent or Guardian.* Record the full name of the father and the mother. If one parent is dead, record the name of the one living and in parentheses the name of the deceased parent followed by the abbreviation, Dec., for deceased. In cases of separation or divorce, record the parent with whom the child is living, followed by the name of the other parent in parentheses with the appropriate designations, Sep. or Div., e.g., Betty Lou Smith (John Ray Smith, Div.) If the child is an orphan, note the name of the legal guardian and also the person or institution with whom or in which he lives, e.g., John Doe, guardian, lives with Mrs. J. N. Smith, Family Welfare boarding home, etc.

11. *Referred By.* Give the actual name of the person or agency referring the child, e.g., Child. Division, Dept. Public Wel-

fare, not just social service; Dr. J. T. Jones, not just physician; Mary Smith, teacher, School No. 9, not just school.

12. *Brought By.* As the person bringing the child is usually an important, if not the first, source of information, his or her name and position or relationship should be recorded.

13. *Date.* This should be the date of the first direct interview (or examination) with the child even though there may have been earlier indirect contacts with the case. The chronology for information secured in later contacts may be indicated under *Complaint History* (Sec. III) or in other appropriate parts of the Blank and in the *Follow-up Record* (Sec. VIII).

14. *Problem* (complaint). The problem or complaint stated here should be that given by the person referring or accompanying the child but, if too lengthy, it may be summarized here and the complaints recorded verbatim elsewhere (see Complaint History, Sec. III). If, as is often the case, it is found that the real problem is different from the one stated here, attention may be called to the difference in the *Summary* (Sec. II).

15. *Examiner.* The Blank should be signed on the first page by the person who has primary responsibility for the case. Information secured and recorded in different sections of the Blank by different individuals should be signed separately in those parts.

Section II Diagnostic Summary

The examination of a child is essentially an analysis of his behavior equipment (achievements, skills, habits, attitudes, abilities, capacities, etc.) and of the things, persons and events which have influenced his behavior development (27, pp. 116-135). The following sections of this manual may suggest an outline of examination procedure for reconstructing the child's behavior history and securing a cross-sectional sample of his behavior as it appears at the time of the investigation. In the present section we are concerned with matters of diagnosis, prognosis and recommendations which are to be made upon the basis of this examination. Space is allotted for these headings in Section II on the face sheet of the *Psychodiagnostic Blank.*

1. *Diagnosis.* Diagnosis is the synthesizing or piecing to-

gether of all examination results into a brief descriptive conclusion about the given child's difficulties (26, p. 113; 33, pp. 5-7). The diagnostic statement recorded here should include: (1) a general best-fit description or classification of the child's problems; (2) specific and definitive measures, estimates or examples of special abilities or disabilities, achievements, skills, problem behaviors or personality maladjustments (33, pp. 207, 257); and (3) the etiological and concomitant conditions most prominently associated with his difficulties. While such general descriptive terms as Feeble-minded, Normal, Superior, Conduct or Behavior Problem, Personality Maladjustment, etc., are necessary and useful in a generic sense, when used alone they lack the specificity necessary to inform the examiner properly at a later time about his conclusions. Moreover, without further qualifications they are even less informing to another person since such terms mean different things to different persons.

For these reasons, the diagnostic statement should also include more definitive descriptions in terms of both the quantitative and qualitative psychometric results and other more specific features of the child's behavior equipment as may have been observed by the examiner or reported by informants. Although a table for test scores is included in this section of the Blank to accommodate quantitative test results, one must not lose sight of the equally important qualitative results of the examination and the biographical and other data. With these reservations in mind, the approximate schedule of test quotients used at the Indiana University Psychological Clinics (33, p. 56) are included here.

Idiot	0 to 15 — 20
Imbecile	15 — 20 to 45 — 50
Moron	45 — 50 to 60 — 65
Borderline	60 — 65 to 70 — 75
Very low or dull normal	70 — 75 to 80±
Low normal	80± to 85±
Slightly below average	85± to 90±
Average	90 to 110
Slightly above average	110 to 115
Superior	115 to 130
Very superior	above 130

These values are based principally upon the Binet performances

or upon consistent performances on several types of tests. The overlapping of the boundaries between each of the above groups indicates the fact that exact diagnosis cannot and should not be made on the basis of IQ's alone, but must rest upon a careful consideration of the qualitative test results and of the child's case history.

The diagnostic statement should further include the etiological and concomitant circumstances uncovered in the child's case history which account for his behavior difficulties, e.g., organic disabilities, socio-economic factors, experiences with members of the family, neighborhood, school, etc. The inclusion of such circumstances may make not only the child's problems more understandable but also the prognosis and recommendations made for the case.

2. *Prognosis.* Under this heading a forecast of the probable outcome of the child's problems should be recorded. This prediction, which is an integral part of the diagnosis, should be grounded in a proper regard for all the data known about the child and in an understanding of the circumstances he is likely to encounter in the future. Except in cases where there is little doubt regarding the future, as with obvious idiots and imbeciles, the prognosis is necessarily made with caution and qualified against exact interpretations others may give it. Wherever possible, the clinician should state what one may expect from the child in general. For example, the educational expectations of children with different test ages is suggested from the data in the table below, which is reproduced here from Louttit (33, p. 56).

MENTAL AGE STANDARDS FOR THE DIFFERENT GRADES

Grade	Average Mental Age at Beginning	Mid-grade	End
I	6-6	7	7-5
II	7-6	8	8-5
III	8-6	9	9-5
IV	9-6	10	10-5
V	10-6	11	11-5
VI	11-6	12	12-5
VII	12-6	13	13-5
VIII	13-6	14	14-5
H.S.I.	14-6	15	15-5

Psychometric and other data may also afford a basis for other approximate predictions such as ultimate grade achievement in school, probabilities of success for vocational training and for certain occupations, and general social and economic adjustments (33, pp. 139-162).

The prognosis for conduct, behavior and personality problems depends upon such factors as the etiological and concomitant conditions, present circumstances, available remedial facilities and future events. In the case of a younger child, especially a pre-adolescent, future change is largely a matter of what can be expected of his parents, teachers or other interested adults since he seldom has enough insight or ability to do much for himself. The prognosis for older children may depend to a greater extent upon their insight and desire for help as well as upon cooperation from responsible adults (33, Part III). Behavior disorders associated with organic pathologies may be largely medical problems the prognosis of which depends upon suitable treatment as such. Again, the outlook for special disabilities associated with sensory or other defects is usually dependent upon medical correction and special remedial procedures (33, Part IV).

3. *Recommendations.* These should embody a plan for the treatment or handling of the case. Usually this plan is to be carried out, for the most part, by parents, teachers, social service workers or others. Accordingly, all recommendations should be listed separately and recorded here in a specific, detailed and clear enough manner that psychologically untrained people can follow them. Moreover, they should be made with a realistic regard for the facilities available and the abilities and limitations these persons have for following the recommendations. For information on the subject of the treatment of children's problems, the reader is referred to Leo Kanner's *Child Psychiatry* (26), C. M. Louttit's *Clinical Psychology* (33) and Carl R. Rogers' *The Clinical Treatment of the Problem Child* (41).

The following examples may illustrate the several matters discussed in this section:

(1) *Diagnosis*: Feeble-minded, low grade imbecile level, probably associated with birth injury. Although 10 yrs. old, he pre-

sents a convincing picture of the behavior development of a child not over 2½ yrs. of age.

Prognosis: Will always require close supervision. Ultimate maximum behavior development as an adult will probably be that of a 3 or 4 year old child.

Recommendation: Permanent institutionalization (name of school in parentheses).

(2) *Diagnosis*: Borderline performance level with good mechanical ability and a keen interest in "building things." Truancy, fighting and class room behavior seem to grow largely out of school situation where he is in 6A grade although he is capable of doing only about 3rd grade work.

Prognosis: Has about reached his ultimate academic limit of 3A or 4B grade work. Conduct problems will probably continue and may grow even worse unless pressure of competition lessens. Patient is more trainable than educable.

Recommendations: 1. Transfer to special ungraded class where more emphasis can be given a manual rather than academic type of training.

2. Encourage his interest in "building things" and participation in social and other activities with children more nearly his own age, size and ability.

3. Report on progress 1 mo. hence.

(3) *Diagnosis*: Average general performance level except for special reading deficiency probably associated with poor vision. Has an excessive timidity growing out of maternal overprotection. Is in 6th grade but is capable of reading on about a 3A grade level.

Prognosis: Favorable for improvement with proper home training program and attention to school and other outside adjustments. Remedial reading should be successful, visual defect permitting.

Recommendations: 1. Should be allowed and encouraged to do more for himself at home and in general.

2. Encourage to participate in extracurricular activities at school, particularly individual sports such as boxing, tennis, etc.

3. Eye examination.
4. Remedial reading if and as eyes permit.
5. Interview with parents 2 wks. hence to check on their progress in carrying out above recommendations.

Section III Complaint History

Under Complaint History should be included a full description of the child's reported complaints, their onset, type, frequency and usual methods of handling; his typical behavior traits and relevant social factors together with the names of informants and the date on which the information was secured. In Section III of the *Psychodiagnostic Blank* no rubrics are provided to record this information since none can be devised which will fit a large enough number of cases. However, we will make some suggestions here that may illustrate the procedure for obtaining the complaint history from, first, adults, and, second, the child.

A detailed account of the child's complaints and characteristic behavior traits is usually secured from parents, teachers or other interested adults (26, pp. 25-30; 33, pp. 13-15). The amount to be secured depends upon the nature of the case, e.g., in more obvious cases such as idiocy or imbecility a brief description of the child's behavior traits may suffice, while in others a very extensive description may be only an introduction to more subtle and complex problems. If a child is more than two years of age, he should not be present during the interview with his parents or other informants. Often this separation reveals much about both the child and his parents. Signs of adult overprotection and overdependence on the part of the child, or any other unusual behaviors, should be noted. In the case of an older child, particularly an adolescent who has a behavior problem, it is usually better to interview informants before the child comes to the clinic in order to minimize the possibility of being identified with any suspicion or hostility that he may have for the informants.

The identifying data (Sec. I) having been secured, the first step in obtaining the complaint history is to inquire of the informant, "What is the trouble?" "Why have you brought this child here?" or some similar question. All answers should be regarded as

a statement of the problem as the referant sees it and regardless of the language or the inadequacy of the replies they should always be recorded verbatim, enclosed in quotation marks and ascribed to the informant by name. It is a convenience to list the complaints in a numerical order where possible, but the interviewer should avoid translating the complaints into his own terminology. The characteristic expressions of the informant may reveal much about the adequacy, insight and attitudes of the referant whose own problems are very often the basis of the child's difficulties. In cases where it is not possible to record verbatim all the complaint history, as much as possible should be so recorded together with sample quotations which are characteristic of the informant or are otherwise significant.

After the initial complaints are related, it is always well to ask, "Are there any other complaints or difficulties?" Frequently this supplementary question will bring forth complaints of more clinical significance than those initially given by the informant.

The informant's spontaneity for relating complaints having worn off, the examiner should take over the lead with questions designed to gain a clear picture of each complaint and to better establish its *nature or type, time and circumstances of onset, the frequency with which it occurs,* and *the previous methods of dealing with the complaint.* In addition, all suggestions of such behavior traits as may lead to a better understanding of the child should be followed up with appropriate questions, i.e., the presence or absence of socially and psychologically acceptable behavior patterns should be noted such as lying, stealing, truancy, irresponsibility, play and feeding habits, disturbances and habits of sleep, speech defects, enuresis, finger-nail biting, excitability, shyness, preoccupations and any other significant signs of instability or immaturity as well as the informant's attitude toward them.

When the examiner is satisfied that the complaint material is exhausted, he should turn to a more systematic investigation of the child's developmental history and of his parents and family as outlined in Sections IV and V. After these latter inquiries, the examiner is ready to interview the child.

The nature of the interview with the child depends upon his age,

insight, ability or willingness to cooperate and other such factors. An infant or an idiot can only be "examined." But all children capable of enough cooperation should be interviewed in the absence of their parents or other adults. The examiner should be alert to note how the child enters the room; how the child greets him; the child's appearance; his cooperativeness; signs of fear, indifference or hostility; and other aspects of his behavior. Such reactions may not only be of general significance but also provide cues for how best to deal with him. In the event satisfactory rapport is established and it seems desirable, the examiner may proceed to inquire what his difficulty is or "Why did you come to see me?" Very often the child is able to shed considerable light on his complaints, either by direct or indirect accounts. When a child is unable to give a direct account of his problems (e.g., younger children), the examiner may approach them indirectly by asking such questions as are appropriate to the individual case. The following questions[3] may suggest this procedure:

1. What do you want to be when you grow up? 2. Whom do you like best in the world? 3. What do you like to play with best? 4. Do you like to play with girls (boys) or boys (girls) best? Why? 5. If someone gave you a dollar (five dollars) to do with as you wished, what would you do with it? 6. What do you think about when you go to bed?

When the examiner feels that he has obtained all the pertinent information from the child concerning his complaints, he may begin a more systematic inquiry into such features of the developmental history (Sec. IV) and of his parents and family (Sec. V) as may seem profitable. After this, the child is ready for the more formal psychometric examination, provided he is not too fatigued or the situation otherwise unfavorable. In the event of these latter complications, the psychometric examination should be attempted later.

In subsequent contacts, all information as may be secured in the manner outlined above may serve as an invaluable check on the

[3]These questions are from a list supplied by Dr. Edwina Cowan of the Wichita Child Guidance Clinic. For a more extended list see Appel and Strecker (1).

progress of the case. Notes on all additional contacts should be recorded here, giving the date of the interview, the name of the informant and noting any behavioral changes reported. In the event that more space is required for this section of the *Psychodiagnostic Blank*, inserts of 8½ x 11 inch sheets of ordinary typewriter paper may be used.

Section IV Development of the Child

After the complaints and other relevant data have been secured, much may be added to the examiner's understanding of the child's problems by systematic inquiry into such factors of his total developmental history as his mother's pregnancy conditions, birth conditions, his infancy and early childhood development, health history and physical condition, play, educational and vocational history. We do not suggest that the above factors in the developmental history and the rubrics outlining each in Section IV of the *Psychodiagnostic Blank* and described here, constitute a complete history-taking encyclopedia, but only a compendium in outline which has been found to be a guide of great clinical value if used properly. Accordingly, the examiner should by no means limit himself to those items and rubrics presented here but should follow up any promising leads to other information that may appear during the interview. With this in mind, additional space is provided at convenient intervals in the Blank under the rubrics, *remarks*. Where these are not sufficient, the examiner should resort to inserts of letter-sized sheets for more extensive note taking.

1. PREGNANCY CONDITIONS. *Prenatal care*: note the general condition of the mother's health; medical examination and care; diet, exercise and work; habitual use of drugs (incl. headache remedies and cathartics), alcohol and tobacco; and the general hygienic precautions taken. *Accidents*: record any report of accidents during the pregnancy, especially violent ones. *Illness*: indicate the name and nature of any illness, its duration and treatment, its severity and the specific and general effects upon the pregnancy and the mother's health. *Mental condition*: note any emotional upsets, worries, fears, psychoneurotic or psychotic episodes; their

nature, frequency, time of onset and the conditions and circumstances responsible for them.

Because the fetus *in utero* (2, pp. 90-109; 21) enjoys the greatest possible protection against disease and injury, only those diseases (principally congenital syphilis) which are definitely known to have infected the infant and accidents which were obviously violent enough to have damaged the uterus and fetus should be credited with significance (10; 11, p. 459; 15; 23, p. 1; 33, pp. 104-105; 43, pp. 227, 646, 675, 847, 1234; 50). Much more frequently, accients and illnesses affect birth conditions and the postnatal care of the child; while the nature of the prenatal care and mental conditions afford insight into the adequacy of the mother's personality make-up.

2. BIRTH CONDITIONS. *Place*: the place of delivery should be designated together with the name of the physician or other attendants for reference in case other data are required. *Term*: the fetal age at birth should be noted, e.g., "about 1 mo. premature." The viable products of pregnancy are ordinarily identified by age as follows: (43, pp. 178, 862).

1. Premature—pregnancy terminating between the 28th and 38th weeks (24).

2. Full term—pregnancy terminating between the 38th and 42nd weeks.

3. Postmature—pregnancy terminating after the 42nd week (11, pp. 120-121).

Birth weight: weight at birth should be secured as an index of the child's prenatal, natal and postnatal vitality. According to Stander (43, p. 181), DeLee (11, p. 57) and Griffith and Mitchell (23, pp. 3-5) healthy full term babies may vary from 5½ to 11 pounds. Babies weighing only 3½ pounds or less are classed as immature if not premature and those weighing over 10 or 11 pounds as excessively large if not postmature.

Delivery: prolonged, dry, difficult or precipitate labor, breech birth, version-extraction, forceps or instrumental delivery and Caesarian operation (11; 43) should be noted as possible sources of injury to both the mother and child. However, it must be emphasized that many birth injured children are the products of normal

deliveries. According to DeLee (11, p. 140), one may regard anything over 30 hours of continuous labor in primiparae, and over 18 hours in multiparae, as prolonged (8; 43, p. 919). *Mother's condition*: note whether the mother's recovery from delivery was good, slow or otherwise complicated. Mothers are usually able to move freely about the house within 14 to 18 days after delivery (11, p. 229). Interest here is primarily in the mother's ability to nurse and care for the child. In the event she was unable to do so for any appreciable time, it is important to ascertain who cared for him, for how long and under what circumstances. *Baby's condition*: indications of congenital disease or defects, injuries or diseases acquired at or shortly after birth should be inquired about (12; 13; 23, pp. 210-248; 24, p. 248; 49). The following questions will usually suffice to bring out any unusual or significant features:

1. Did the child have any difficulty breathing immediately after delivery? Was he a blue (cyanotic) or very pale (asphyxia livida) baby? Did he breath spontaneously or have to be resuscitated? Did he ever turn blue or pale at intervals after birth? Because of difficulty in breathing?

2. Did he ever have skin lesions (sores, etc.)?

3. Did he nurse at the breast? How early did he begin? If not, what was he fed (formula, canned or cow's milk)? Was he a feeding problem? Vomit excessively? Suffer severe diarrhea? Lose or fail to gain weight?

4. Was he a healthy active baby? Did he cry excessively or feebly? Was he ever ill? Run high or low temperatures? What did the doctor say the trouble was?

5. Did he ever become stuporous, paralyzed or rigid, twitch, toss, roll head, shake, have tremors or convulsions?

6. Were there any (other) unusual features about his babyhood? Answers indicating anything unusual should be followed up with appropriate questions. In the event the reports are suspect or inadequate, the examiner may seek corroboration or additional information from hospital sources, the attending physician or others (see *Place* of birth above).

3. INFANCY. *Developmental profile*: The profile of infancy and early childhood development is composed of 12 very common and

diagnostic items. Age norms obtained from the most reliable sources available were reduced to months and arranged after the manner of rating scales which afford a quick means of recording and comparing features of early development. While no standardized scoring system is attempted, the profile has been found to be of great value in detecting early maturational trends, both physiological and psychological. For example, by means of a large check mark interpolated in the appropriate part of each scale corresponding to the reported age of performance, one can see at a glance whether the infancy development was superior, average or retarded. The extremities of each scale are left blank so that unusually early or late performance ages can be recorded by filling in the exact age, e.g., in the event that the first tooth appeared at 15 months, "15" would be written under the dot on the extreme right of scale 3 and a check made on the line above. To the right of each scale item, space has been provided for such qualifying remarks as may be advisable to record, e.g., special situations due to illness, accident, lack of specific training, unreliability of information, etc. Although the serviceability of the scale depends upon the accuracy of the mother or other informant, who should bring a baby book or other records to the interview if possible, it has been found to be of considerable value even when the informant can give incomplete or only approximate information. While no information at all from a mother may reveal little specific data about the child, much may be inferred about the mother's adequacy. Care should be taken that a mother does not confuse the patient's age of maturation with that of his siblings or the normal age at which children *should* perform certain acts. When this is suspected, a word of caution to this effect is usually sufficient to elicit more reliable information.

Breast-feeding and Weaning: the length of time the child was breast-fed and the age when solid or semi-solid food was introduced, i.e., partial weaning from the breast or bottle. Under normal conditions a baby should be nursed about 8 months, or not less than 6 nor more than 10 months (23, p. 64; 36, p. 58; 38, p. 136). When ages outside these limits are reported, the mother should be asked why she did not nurse the child longer, or as long as she did, as the case may be. The validity of such answers may be gauged by

whether or not the mother acted on advice of physician. In the absence of valid reasons (e.g., failure of milk supply, disease, hot weather, etc.), too early termination of breast-feeding may indicate a rejection of the child. On the other hand, prolonged nursing may signify overindulgence. However, such indications of an abnormal maternal attitude require more conclusive evidence as they may be only signs of ignorance and therefore important for different reasons.

Very much the same things apply to the age of weaning, save that the child may have been artificially fed. Refusal of solid or semi-solid food, whether it agreed with him and especially how the parents met the baby's objection to food changes should be noted (see 33, pp. 298-306 for feeding problems). The age norms used here are deductively arrived at from several sources (23, p. 71; 36, p. 88; 38, p. 137). Unlike other items (nos. 3-12), both extremes of the breast-fed and weaned scales may indicate unusual conditions.

First tooth: age at which the first tooth (middle lower incisors) erupted. Griffith and Mitchell (23, p. 20) and Morse (38, p. 95) give 6 to 8 months as the most usual time of eruption. While there are many normal variations, extreme delay or irregularities of eruption may be symptoms of disease (i.e., rickets) provided, of course, other disease signs are present. Occasionally children are born with some teeth already erupted. Usually the baby's first tooth is a remembered event and occurs at about the 7th month. Few parents remember additional eruptions unless they are unusual in some way.

Fed self (with spoon): age at which a child first began to use a spoon effectively in feeding himself. This item is largely dependent upon training and health. The norms used here are deduced from Doll (14).

Bowel Control: age at which bowel control was established. This may be taken to mean the age after which soiled diapers were unusual or the age at which evacuation was habitually established. This will vary widely with the amount of training. With constant training during the first year (starting as early as the second month), the child can be expected to have a habitual rhythm of one action per day by about the 12th month (20, p. 142). If no train-

ing has been given, the age will be much later but, in any case, adequate control should be established by the time the child is 2 years old (14; 18; 19).

Bladder control: age of *daytime* and *night* dryness. Bladder control is also a matter of training, acceptable habits by day being established in average children at about 18 months. Bladder control at night is usually established later, from $2\frac{1}{2}$ to 3 years is a satisfactory average. Lack of daytime control after 2 years and bed wetting after 3 years of age may be classed as enuresis and should be carefully investigated (26, p. 231; 33, p. 305; 38, p. 667).

Locomotion: ages of *sitting alone, crawling,* and *walking alone.* There is a rather wide range within which the first appearance of the various features in locomotor development are considered aver age. However, according to Shirley (42), the sequence of the major features appears uniformly in a given child. The age at which these various features appear is affected to some extent by the weight and health of the child and by the amount of specific training given. Gesell and Thompson's normative placement for these acts are: (20)

Sitting momentarily alone	32 weeks
Crawling by any method	48 weeks
Walking alone	56 + weeks

Talking: age at which child began saying *two syllables* (ma-ma, da-da) and *using two or more words.* Data secured from parents on the age of talking must be carefully checked. They are apt to call relatively meaningless vocalizations talking, especially if a baby makes sounds which are like words. For this reason the age at which a child began talking should be defined in terms of the actual words said. Gesell and Thompson (20) place the saying of 2 syllables at 8 months, the use of two words at 12 months and Gesell (19) the use of short sentences at about 24 months. Terman (46) gives the following data for the ages at which children begin to talk in general:

Group	Median Age	Age Range
Normal	15.80 months	9-25 months
Feeble-minded	34.44 months	12-156 months
Superior	12.00 months	6-24 months

Any other significant features of development should be noted under the heading, *remarks,* i.e., illnesses, lack of interest in surroundings, slowness in learning to dress self and in social relations. Likewise, the converse of these activities should be recorded, i.e., development of habits and activities at a precocious age.

4. HEALTH HISTORY AND PHYSICAL EXAMINATION. Under this heading there should be recorded in chronological order all diseases, illnesses, operations, unexplained symptoms, accidents, and the pertinent findings of any physical examinations. The severity (temperature, delirium, convulsions, etc.) and the duration of the illness together with information about the nature of the recovery should be noted in each instance. Similar information about accidents and operations should also be secured. The date of all medical or physical examinations including the name of the examining physician (or others) should be recorded. The following examples will illustrate:

a. 6 mos.—whooping cough for about 5 wks.—severe, had about 10 or 15 convulsions—almost died—slow recovery.
b. 3 yrs.—pneumonia—in bed 10 days—temp. 105°—slow rec.—temper tantrums began after rec.
c. 6 yrs.—fell 5 ft. off back porch—broke collar bone—uneventful rec. but delayed starting to school until next semester.
d. 8 yrs. (3-3-37) physical exam. by Dr. Clese at County Hospital found:
   1. poor vision—glasses prescribed.
   2. 15 lbs. underweight.
   3. hyperactive reflexes & positive Bl. Wassermann. (attending C. H. Clinic regularly for treatment).
   4. T. B. findings neg.

   Has had frequent colds since age 5—gained 10 lbs. in last 8 mos. No eye complaints since glasses worn.

In addition to actual physical impairment, any severe illness, operation or injury may be important as an occasion favoring the development of a spoiled child, an attention-getting "invalid," and a variety of other behavior disorders. An unusual change in a

child's behavior following illness should be investigated with these possibilities in mind (26, Ch. VI & pp. 157-164; 33, pp. 598-612).

5. PLAY HISTORY. The child's play interests, activities and choice of playmates (5; 16; 33, pp. 342-345; 44, Chs. XI-XII; 48) usually reflect any behavior pathologies (30; 31; 46). The following questions may reveal much of importance about a child, depending upon their applicability to a given case: Does he like to play much? What does he play with (specific toys, games or persons)? Does he know how to play? How well does he play with other children? How old are they? With what age child does he prefer to play? What do they play? What games? Where do they play? Why there? Does he have trouble with his playmates? What difficulty does he have? Any unusual reports such as younger or older playmates, abnormal reactions to his coevals or unpopularity with them and immature or abnormal play interests or activities should be looked into, together with the opportunities and facilities for normal play. It is a good practice to question the child himself about who his playmates are, their ages, what he likes to play, etc.

6. EDUCATIONAL HISTORY. The following information about a child's educational history is suggestive of the material that may be of importance to the clinician. *Pre-school*: *age* when attended, *how long* and *name* of nursery school or kindergarten attended. How well did he adjust? In certain cases when admittance was refused or when he attended only a short time, why? *School*: age *entered first grade* in years and months and whether he started in the fall or spring semester. Explanations should be sought for children entering before the age of six or later than seven years. All grades *repeated* should be listed and a note made of how many times he was in the same grade, e.g., "1A, 2B, 3A (2x's), and 4B" or "none." Three or more years of retardation in school should arouse a suspicion of feeble-mindedness or at least of some unusual behavior pathology (33, p. 116). On the other hand, it must be remembered that deficient children are often promoted on the basis of size and appearance rather than actual achievement. Any *grades skipped* should also be noted. Although acceleration in grade placement is evidence of superiority, few superior children are advanced in grade for their chronological age (33, pp. 244-245). Explana-

tions for grades repeated or skipped should not be overlooked. As marking systems vary a great deal, probably qualitative estimates of school work in terms of *average marks* are all that can be secured. Letter ratings might be used, e.g., A—excellent, B—good, C—average or fair, D—poor, F—failure or very poor. Year by year changes in a child's average marks should also be investigated. All the different *schools attended* by the child should be listed together with the dates and grades, reasons for change and any difficulties the child may have experienced as a result of the change. Frequent changes in school are often associated with school disabilities, general retardation and maladjustment (33, p. 173).

Any irregularities in school *attendance* should be noted and accounted for (33, p. 179). The time lost on account of illness should be ascertained in terms of the approximate number of weeks in various grades. If the time is less than 2 or 3 continuous weeks, i.e., if several periods of a few days are lost because of colds or other minor illnesses, the exact time may not be given unless it is otherwise important. Truancies should be entered as such only if absence is not due to illness or home conditions.

The *teachers' attitudes toward the child* should include a brief estimate of the child and his work and an explanation of his difficulties, if any. Often a statement from the principal about the child and the teacher's general relationship to students sheds light on anything unusual in the school situation. Again, an estimate of the teacher's attitude by a parent or other person may be different from that of the teacher herself.

The *child's attitude toward school* should be secured from the child and recorded as nearly as possible in his own words. As many children have stereotyped answers to such questions as "Do you like school?" the examiner should exercise care that the rapport is good and that the child's answer is consistent with his other remarks about school. This can also be checked by pertinent statements from parents, teachers and others.

The *parents' attitudes toward the school* ought to be carefully investigated for misunderstandings, negligence, irresponsibility, cooperativeness, interests, hostilities, etc. Pertinent cues may appear in their discussion of the child's truancies, his average marks, grade

placement and school conduct. Such leads should be followed up by direct questioning if necessary until the examiner is satisfied that he has a reliable picture of how the parents feel toward the school. Their attitudes may be checked against the school's report on its experience with the parents.

School subjects should be listed in order of *preferences* and *dislikes,* e.g., "What subjects do you like best?" "Next best?" etc. After three or four preferred subjects are given, "Are there any you dislike?" "Which do you dislike most?" "Next?" etc. Likewise, the *best* and *poorest* grades or marks should be secured, preferably from school reports, and listed in rank order. Usually there is considerable correspondence between a child's preferences for school subjects and the grades he receives. Any noticeable discrepancies should be inquired about. Dislikes and poor grades in a given subject may indicate unfavorable teacher-student relations, a specific disability, or an antagonism to or lack of interest in that subject. Again, certain subjects are harder, and, therefore, more often disliked by dull or retarded children, i.e., mathematics, science and the more abstract subjects. Rather, these latter children often express preferences for and make their best grades in such subjects as music, art, spelling, shop and the more manual subjects (33, p. 117).

7. VOCATIONAL HISTORY. The vocational history should include the *age* at which the examinee got his first remunerative job even if it was only part-time work; the *kind* of work and by whom employed; whether or not he had *working papers,* where issued and the *date.* Subsequent *positions held* should be listed in chronological order, giving the dates of starting and stopping, the nature of the jobs, the amounts of money earned and the reasons for quitting. In addition, the examiner should not overlook the importance of work habits and interests, reasons for working, how money earned was spent, etc., in cases where such matters may be of significance.

Section V Parents and Family

The purpose of this part of the interview is to secure an adequate picture of the family in which the child has lived and, in most instances, will continue to live. In the main, there are four general conditions that should be investigated: (1) the cultural and intel-

lectual level of the family; (2) its economic status; (3) the familial attitudes prevailing in the home; and (4) the hygienic conditions under which the family lives. These conditions may be not only of great etiological importance but also determine the family resources available for bringing about any desired change in the child's behavior. But in securing this data, the emphasis should be upon the adjustment various family members make to each other, especially as it affects the child's problems, rather than upon the collection of discrete facts. The first step is to identify the various individuals comprising the family, after which the examiner is in an advantageous position to follow up any cues that give promise of shedding light upon the often very complex intra-family relationships (26, pp. 86-106; 33, pp. 265-291).

1. FATHER. His *age* need be secured in years only. *Birthplace*: city (or county) and state; if foreign born, secure the name of the country and the place if possible (33, pp. 180, 206). *Education*: the grade attained in school, the age of leaving school and if possible the quality of school work, e.g., "8th gr. at 16 yrs., failed 2nd & 8th grs." Also, the circumstances under which he left school may be significant. *Religion*: the church affiliation or absence of affiliation should be noted. Membership in a fanatical or unusual cult or religious convictions that clash with those of his wife or other members of the family should not be neglected. *Occupation*: record the type of work done, such as farm hand, pattern maker, elementary school teacher, bank president, etc. (33, pp. 152, 232). *Employed by*: name of employer and other details necessary for checking. *Salary*: is best computed in terms of yearly wage or income. If wage is on a weekly, hourly or piece basis, the approximate per year amount should be determined and any significant income irregularities noted (33, p. 274). *How long employed here*: state in years and months. Frequent change of jobs and the reasons for such changes should not be overlooked. *Health history*: ascertain present state of health and, if in poor health, note the cause and length of time he has been ill. Inquire about any serious illnesses or accidents, particularly tuberculosis, heart disease, "blood or skin diseases" (syphilis), cancer, diabetes, mental and nervous or glandular disturbances. Note any special de-

formities, excessive height or weight, goiters, tics, mannerisms, etc. (33, p. 270). *Excesses*: note whether or not there is or has been an habitual use of *alcohol, drugs* (incl. tobacco and medicines) or indulgence in excessive or irregular *sex* practices. *Death*: in the event the father is dead the *date* and *age* at death, the *cause* and any other circumstances of importance should be ascertained (33, p. 272). Space under the heading *remarks* is provided in the *Psychodiagnostic Blank* for recording any additional information about the father such as standing in the community, conduct, criminality, court record, dominant personality traits, temper, habits, peculiarities, unusual abilities or interests and the examiner's impressions of his general attitude toward the child's problems (i.e., insight, cooperativeness, etc.).

2. MOTHER. The data here are the same as those which should be secured for the father except for a few additional items. These are: *work since marriage*, an approximate estimate of the *frequency* of employment outside the home and the nature of the *occupation*, e.g., house maid, teacher, store clerk, etc. *Care in mother's absence*: should include the name and relationship of the person caring for the child and the nature of the care (in case of mother's regular absence for any reason), e.g., by hired girl, sister, boarding home, etc. Under *health history* reports of "female trouble, blood or skin disease" should prompt questions about the appearance of a rash and the nature of the treatment received as they may be symptoms of a venereal disease. Direct questions about syphilis or gonorrhea should never be asked about by name unless the mother first mentions it herself. Such information should be secured from a physician or a hospital source.

The above items are intended for the child's own parents. But where one or both parents are dead or for any other reason (e.g., abandonment) the child has never lived with them or only for an inconsequential length of time, the fact should be noted under *remarks* and the information as indicated above secured for the foster or step-parents. If the child lived for a number of years with his own parents, additional information regarding them should be secured and recorded under *remarks* or in the space provided under the heading *Marital history*. Also, the child's reactions and

attitudes toward foster or step-parents should be noted under *Intra-family Relationships*. If the space provided in the Blank is insufficient, insert sheets should be used.

3. MARITAL HISTORY. *Present status*: married, unmarried (in cases of illegitimate or sometimes adopted children), divorced, separated, widow(er), remarried. *How long married* and *where married?* This information should be entered as it is sometimes necessary to check this for other data. Previous marriages and whether or not there were any children by them should be inquired about (the name, age, etc., of foster or half siblings to be recorded under *Sibilings*). The examiner may record here the more or less factual history of any separations or divorces and reserve further inquiry until the rest of the family is identified and he is ready to go into the intra-family relationships (26, p. 90; 33, pp. 271, 382).

4. SIBLINGS. List in *order* of birth all true siblings of the child (including all miscarriages and still births the child's mother may have had and any siblings who may have died), identifying each by *name, age* and *sex,* and ascertaining for each his or her state of health, educational and occupational status and noting in each case any behavior or condition that might affect the child, e.g., chronic illness, convulsions, delinquency, insanity, feeble-mindedness, etc. Before leaving this part of the interview, it is always well to ask, "Were there any other pregnancies?" Numerous miscarriages, premature or still births, should arouse suspicion of syphilis, but this possibility should be approached cautiously (11, p. 459). In place of direct questions (using expressions "syphilis" or "venereal disease"), parents may be asked about maternal "skin eruptions," "vaginal discharges," the type of "skin" or "blood" treatment, etc. Any illegitimate births should be so designated. After this, the same information should be secured for any foster or half siblings the child may have, especially those with whom the child lives or has lived.

5. RELATIVES. For each grandparent note his or her name, and if alive, present age, condition of health and whereabouts; if dead, the age at death, the cause and any pertinent disease history, especially mental and nervous difficulties. Beyond this, a minimum

history should include the individual's education, occupation and any unusual personality features that may affect the child's family. The extent of the information to be secured about grandparents and other relatives should be governed by the special circumstances of the case. Particular attention should be given to any grandparent who lives or has lived in the home, who exercises a special influence on the family or one who may be a source of help. For such persons, very much the same information should be secured as that indicated above for the father and mother. The same holds for all collaterals (aunts, uncles, cousins, etc.) and any other persons (boarders, friends, etc.) who may be in a similar relationship to the family. Any that are reported as "criminal," "immoral," "queer," "silly," as being "nervous" or "irritable" or as having been institutional cases should be investigated further, especially their contacts with the child.

6. INTRA-FAMILY RELATIONSHIPS. Having oriented himself with respect to the various members of the family, the examiner can better look into the relationship of each member to the child and his problems (6). Age, educational, religious, social, racial and other differences between parents; their economic status, state of health, excesses and general social and personal adjustments; their marital history; data on the child's siblings and others who may be connected with the home, as well as the complaint and developmental history, usually provide cues, where significant conditions exist, for a more direct inquiry into intra-family relationships (26, pp. 86-106; 33, pp. 265-291). All such leads should be followed up with appropriate investigation. The discussion under the following headings may suggest what to inquire about.

(A). *Attitudes of parents.* (1). Attitudes of parents towards each other are usually reflected in their behavior towards each other. Quarrels, fights, alcoholic excesses, extra-marital relations, desertions, separations, divorces and other symptoms of a lack of unity and harmony between parents, augur a history of discord in the home that is never without effect upon children (9). In cases of behavior disorders, these etiological conditions should not be overlooked. For example, how much interest do the parents take in the home? Does the father spend much time there? Doing what?

If not, why not? Do they quarrel? For what reasons? How often? How long have they been in the habit of quarreling? Do they quarrel in the presence of the child(ren)? etc.

(2). Parental attitudes toward other adults in and outside the home frequently have repercussions upon the child, e.g., in-laws, boarders or friends may be a source of parental discord or, again, they may spoil, frighten, excite or set bad examples for the child. Attitudes towards other adults are sometimes of importance, e.g., neighbors who do not accept the family because of social, racial or other discriminations.

(3). Parental attitudes toward social and moral institutions as in the case of foreign born, fanatical, chronic dependent, alcoholic, criminal, immoral, eccentric and socially unusual parents sooner or later force the child to accept or reject parental training or examples of conduct and frequently result in feelings of insecurity, inferiority, frustration, rebellion, etc.

(4). Undesirable parental attitudes toward the child may be classed into four groups: *First,* oversolicitude, overindulgence and overprotection tend to keep the child from growing up and result variously in such symptoms as baby talk, retarded speech, delayed bowel and bladder control, prolonged help in dressing, finicky and irregular feeding habits, irregular sleeping routine, temper outbursts and often regular tantrums, hypochondriases and demanding, dependent and self-centered attitudes in the child. *Second,* parental overambition or pressure attitudes are often responsible for a child being pushed beyond his abilities in educational or other activities. This often happens where superior parents have a mediocre or inferior child, where the child's siblings are superior or where the child has to compete with superior children in the neighborhood or at school. The resulting strain is met by a curtailment of healthy recreational activities or rebellion in the form of spitefulness, hypochondriases and various types of behavior disorders. *Third,* rejection attitudes as expressed by parental indifference, neglect, hostility and abuse may grow out of marital unhappiness, increased economic burdens brought by the child, interference with parental activities, doubtful paternity, illegitimacy, etc.; and result variously in retardation, fearfulness, shyness, de-

fensiveness, aggressions and hunger for affection. *Fourth,* attitudes of antagonism vs. favoritism are usually related to preferences for a certain child or other children by one or both parents. In addition to the above mentioned circumstances, one child may be discriminated against because he resembles a disliked relative, because of his sex or appearance or because he does not come up to expectation, etc. Often with the arrival of a new baby there is a shift in parental favor which endangers both children, e.g., the favored child may be overindulged and protected while the non-favored child may develop not only jealousy and resentment against the sibling but also become antagonistic towards the parents who in turn may reciprocate his feelings.

(B). *Discipline.* Although some parents may be too defensive or unable to reveal much about their true attitudes toward the child, they are usually willing to discuss more freely their discipline problems. Often the methods they employ tell a great deal about their attitudes and adequacy, and the results, just as much about the child's attitudes. Frequent whippings, excessive leniency, bribery, inconsistent discipline, etc., may well be signs of limited resourcefulness on the part of parents. Again, severe and frequent whippings and other drastic measures may be associated with parental rejection; unreasonably stern and exacting discipline, with pressure attitudes; excessive leniency, bribery and inconsistent methods, with parental oversolicitude; and inconsistent and conflicting measures as between parents may be a sign of marital difficulties, depending upon the individual case. Such questions as the following may serve to obtain the discipline history of a child: What are the usual methods employed? How often are they used? For what offenses? Have the parents always been consistent, presented a united front to the child or does the child play one parent against the other? Are there parental conflicts or disagreements over disciplinary measures or over the control of the child? Is one parent more responsible for discipline than the other? Does the child require more discipline or a different type than his siblings? Does he feel unfairly treated? etc.

(C). *Attitudes of the child.* The child's attitudes are almost always reflected in his behavior toward his parents, siblings, home,

school, playmates and toward society in general. We have already discussed the attitudes of children toward many specific persons and situations. They often loom prominently in the child's complaint, educational, play and general personal history. In light of our previous discussion of parental attitudes, the significance of such questions as the following will be apparent: What are his attitudes toward his home? Is he secretive (keeps things to himself)? Quiet or withdrawn? Is he happy when at home? Does he prefer to play away from home? Like to bring his friends home with him? Run away or stay away from home for long periods? Does he have preferences or antagonisms for other members of the family? etc.

7. HOME AND NEIGHBORHOOD. Usually the examiner has to rely upon social workers for adequate information about the home and neighborhood, as well as for other data about the family. However, where such facilities are not available, he must work under the handicap of less objective reports from parents or other informants. On the other hand, even with reliable social service reports it may be valuable for the examiner to take enough history personally from informants to see what their attitudes and reactions are toward the neighborhood and physical home conditions (26, pp. 100, 105; 33, pp. 290, 385). The following suggestions have been found to be practicable for clinic interviews. *Home accommodations*: what sort of house (frame, brick, stone, single, duplex, upper or ground floor apartment)? The number of rooms and how many used for sleeping? Who sleeps with the child or how many sleep in the same room? Sleeping with someone else, particularly an older person, may be of great importance, e.g., parental overindulgence (26, p. 100). What space is available for play, both in the house and in the yard? *Tenure*: how long has the family lived in the present location? Where previously? Do they move often and why? Frequent movings may indicate unstable economic conditions or difficulties with neighbors. In any case, they make for unsettled home conditions and often overtax the child's ability to adjust to new neighborhoods, schools and coevals. *Ownership*: if the home is owned, give the approximate cost and the amount of the mortgage, if any. If rented, ascertain the month-

ly rent paid. *Furnishings*: unless a report is available from someone who has visited the home, the examiner will have to confine himself to inferential material as may be brought out by such questions as the following: Do you have a radio, piano, victrola, etc., and how old are they? How many books do you have? What kinds? Who reads them? What magazines and newspapers do you take and how regularly? What kind, model and size car do you have? What kind of electrical appliances (stove, heater, iron, washing machine, etc.) do you have? What kind and how much food do you have? Additional questions about sanitary facilities, lighting, ventilation, care of the home and other pertinent matters may be employed as the case indicates.

Neighborhood: including places available for play (playgrounds, open fields, lots, streets, etc.). Where does the child usually play? Where does he play when it rains? Are there any pool rooms, bar rooms, or other doubtful places in the neighborhood? Does the child frequent them? Does the church or school provide recreational facilities, play rooms, playgrounds and the like when they are not in session? Unusual recreational activities or lack of facilities should be followed up with suitable inquiries until the examiner feels he has a reliable picture of the child's neighborhood relationships.

Section VI Psychometric Data

Having secured as adequate a history as possible of the child's problems, behavior growth and the conditions under which he has developed, the examiner is better able to select the most applicable psychometric tests and secure by means of these tools a cross-sectional and more definitive sample of the child's behavior (for description of tests see Buros, 7; Garrett & Schneck, 17; Hildreth, 25; Kent, 29; Lord, 32; Louttit, 33, Ch. III; Mitrano, 37). Section VI[1] of the *Psychodiagnostic Blank* provides space for recording

[1]Section VI of the *Psychodiagnostic Blank* is available as a separate six page folder for use in re-examinations. It can be inserted in the Blank which serves as a filing folder. These inserts may be obtained from the Psychological Corporation, 522 Fifth Ave., N. Y. C., or from the Principia Press, Indiana University, Bloomington, Ind., at a cost of three cents each with a discount on quantities.

both the quantitative and qualitative data obtained from the majority of the most commonly used psychometric tests, e.g., several revisions of the Binet, vocabulary tests, Kent Oral Emergency Test, Draw-a-Man, Healy P. C., the Arthur and Pintner-Patterson performance scales, various formboards, Porteus Maze, etc. Here one needs only the materials for a given test and the instructions or a copy of its regular blank as a guide for administration. The actual results of the test's items are recorded in the blank tables and the responses or other information conveniently written elsewhere in the Blank. Of course, these facilities do not lend themselves to all tests; namely, group tests, self-administering tests and some individual tests with special inherent devices and complicated recording requirements. However, when such are used, their test blanks may be inserted in the *Psychodiagnostic Blank* which serves as a filing folder.

The following instructions for the use of these innovations in the *Psychodiagnostic Blank* may indicate their applicability. 1. LANGUAGE TESTS. The blank table may be used for recording successes and failures for almost any form of the Binet[5], changing the column and row headings if necessary. The numerals in the first column are for the items within the year group. The top row (age group) is intended for the various year levels, e.g., V, IX, etc. In the bottom row the total credit in months for the given year level may be recorded. In the boxes it is recommended that passes and failures be recorded as follows:

\+ for pass
— for failure
R for refused
⊙ for credit given although the item was not presented
⊖ for credit not given although the item was not presented
O for items omitted

[5]The provisions here are not altogether adaptable for use with the new Terman-Merrill Revision unless the mazes of Form L, year VI, item 6 and other printed forms are used by having the child trace through tissue paper, or unless they are reproduced by mimeographing (see copyright note on either form of the new revision). However, in most cases, the 1916 Stanford Revision (45) might be used instead since it appears that there is no reliable difference between the two revisions (47, p. 50).

On the same and opposite pages ample space is provided for recording either all or only the characteristic responses of the child, as the examiner prefers. These pages also have a series of numbers in the margins suitable for recording the results of vocabulary lists and the responses to other verbal tests with serial items as, for example, the Kent Oral Emergency Test (28) and the Vineland Social Maturity Scale (14). Again, the examiner may find the right-hand page suitable for drawing items such as copying figures, etc.

2. PERFORMANCE TESTS. Of the two pages allotted for performance tests, the first contains blank tables for several tests, i.e., the Healy P. C., Arthur Performance Scale, Pintner-Patterson Performance Scale, Porteus Maze, various formboards and the Draw-a-Man Test. The rubrics for each table are largely self-explanatory. For example, in the table for the *Healy P. C.* (4) there are two columns. The first is for the block numbers and the second for the credit points allowed. In the *Arthur Performance Scale* (3) the first column is for the scores of each of the eighteen items and the second for the points credited. The first column of the table for the *Pintner-Patterson Scale* (39) is intended for the scores attained in each of the twenty-two test items and the second for the mental ages credited. In the *Porteus Maze* (40) table the first column is for recording the number of original trials and the second for the inverted trials. The table for *Formboards* provides space for the names of six tests; columns numbered 1, 2 and 3 for the times required for the first, second and third trials; a fourth column headed %ile for the percentile ratings of the first, shortest or average times or other scores that may be required; and a fifth for the performance ages derived from these scores. Directions and norms for all important formboard tests will be found in Bronner, Healy, Lowe and Shimberg (4). The table for the *Draw-a-Man Test* (22) consists of three rows of numbers corresponding to all allowable credit numbers so that in scoring a given drawing the examiner need only encircle the items credited. In giving this test, an 8½x11 inch insert is recommended.

Each of the above tables includes headings for recording for each test the total score, mental age and the percentile rating

where such numerical scores apply. These and all other test scores should be entered in the summary table for test scores on the face sheet of the Blank (see Sec. II). Part of the adjacent page is left blank for recording observations of the child's responses, such as reasons for failure and other qualitative aspects of his test performance.

3. NOTES ON EXAMINATION. The latter part of this page is reserved for notes on examination. The conclusions and observations drawn from all test results should be integrated and summarized here. This summary should take into account the following considerations:

(1). The general performance level, in developmental or mental age, that best characterizes the child's observed behavior in terms of both the quantitative and qualitative results.

(2). Evidences of any special abilities or deficiencies that may have unduly rewarded or penalized the child, e.g., any atypical performances as in memory (memory span), use of language (vocabulary and reading), arithmetic or number concepts, comprehension and understanding, orientation, form discrimination, mechanical aptitude and ability, etc.

(3). Evidences of any sensory or other physical defects that may have influenced test results such as defective vision, hearing, motor coordination, etc.

(4). The nature of the interpersonal relationships between the child and the examiner, especially those that may have influenced the test results such as fear, embarrassment, apathy, hostility, overdependence, shyness, timidity, withdrawing or even psychotic symptoms. Instances of fatigue or of the child's need to relieve himself should also be noted.

The following table suggests the various types of test behavior that the examiner should note and take into account as they appear to affect the test results or as they may be otherwise significant in suggesting the personality traits of the child.

I. COOPERATION.
- A. works with eager interest in new problems
- B. readily attacks new problems
- C. average willingness because expected to do the task

D. performs only because he must
E. refuses to perform

II. EFFORT.
A. works to the limit of his ability
B. above average in application
C. average, works only enough to do the task
D. perfunctory, avoids task if possible
E. doesn't try, gives up easily

III. PHYSICAL ACTIVITY.
A. extremely active, constantly moving, agitated, tics or other involuntary movements
B. "nervous" fidgeting
C. average amount of activity
D. prefers quiet, physical activity only when necessary
E. apathetic, avoids movement

IV. MOTOR SKILL.
A. graceful, fine coordination, good control
B. better than average motor control
C. average, plays games or does formboard with reasonable skill
D. clumsy, poor coordination
E. great lack of control in motor skills

V. VERBALIZATION.
A. very talkative, may or may not be relevant
B. talkative, verbalizes activities, may be somewhat irrelevant
C. average, conversational, in point
D. will not speak spontaneously in strange situations
E. must be urged to talk at all

VI. SELF CRITICISM.
A. extreme criticism of all his behavior
B. criticism of certain activities at certain times
C. average, normal insight into abilities
D. realizes failure or poor work only occasionally
E. entirely satisfied with poor, inadequate work

VII. ATTENTION.

A. can concentrate on task for a long time
B. can be distracted but only by unusual stimuli
C. can be distracted by new stimuli after short concentration
D. easily distracted by new stimuli
E. does not concentrate, attention continually wanders

VIII. UNDERSTANDING.

A. easily understands directions, may anticipate them
B. follows directions without elaboration
C. average, may require elaboration at times
D. directions must be specific and complete before he understands
E. seldom understands directions, or only after a great deal of elaboration and repetition

This summary of the testing situation should be written immediately after this part of the examination is completed or as soon thereafter as is possible before any of the examiner's observations are forgotten or become confused. It should always contain a definite statement of whether or not the examiner is satisfied that the test results represent a reliable estimate or are valid samples of the child's actual achievements, abilities, capacities, skills, etc. Such statements of what the examiner thought of the child's performance at the time are often invaluable to the same examiner or to others who may subsequently see the child.

Section VII Agency Contacts

Under the heading, Agency Contacts, which appears on the back of the Blank, should be noted all known contacts which the child and his immediate family have had with other agencies, e.g., social service and relief agencies, courts, institutions, etc. The possibilities of previous contacts with other agencies should never be overlooked as potential sources of further information. Moreover, because of their previous experience with the child and his family and often because of their facilities, they are the logical allies to turn to for help in handling the case. Then, too, one cannot afford to

jeopardize one's own program and the possible program of others by working independently and possibly at cross purposes with other agencies that may also be interested in the case.

For the above reasons, all contacts should be listed in chronological order with the names of the agencies or appropriate abbreviations for them. The nature or purpose of the contacts should be indicated as well as the length of time the case was active and the extent or number of contacts made by each agency during a given period. The following examples may illustrate these suggestions:

10-2-29 C. H. (for County Hospital)—mother treated 1 yr. as outpatient for "skin" disease.
5-29-32 J. C. (for Juvenile Court)—George placed on 6 mos. probation for stealing bicycle.
7-5-32 C. S. S. S. (for City School Social Service)—John truant over 5 mos. period.
12-6-33 F. W. S. (for Family Welfare Society)—carried as a family problem for about 1 yr.
2-3-35 J. C. C. G. C. (for Jackson County Child Guidance Clinic)—John carried as an enuretic for 9 mos.

In larger communities a social service exchange usually supplies much of this information, but where such facilities are not available, the examiner has to rely upon reports from referring agencies and upon information given during the interview by the child, his parents or other informants.

Section VIII Follow-up Record

The Follow-up Record, which also appears on the back of the Blank, is intended to be used for indicating the chronology and nature of all additional contacts with the child or with others concerning him. It should include the date of each additional contact, the nature of the contact, the name of the person seen, his relationship to the case and the name of the person making the contact as illustrated below:

2-10-37 Conference with Miss Jessie Bell of C. H. S. S. (for City Hospital Social Service) in re: medical exam. for Betty. (signed) D. Wilks.
2-27-37 Interview with Mrs. Jones, foster mother, in re: home training

program. (signed) J. A. Axe.
3-28-38 Re-exam. of Betty. (signed) B. C. Brown.
4-7-38 Speech lesson to Betty. (signed) B. C. Brown.

These entries are a convenience in making periodic statistical reports and in otherwise making the contact history of a case available at a glance by simply turning over the Blank. They are not intended to take the place of actual notes on additional contacts. To the contrary, all such notes should be fully recorded under *Complaint History* in Section III, on insert sheets or in other appropriate parts of the Blank.

BIBLIOGRAPHY

1. Appel, Kenneth E., and Strecker, Edward A. *Practical examination of personality and behavior disorders. Adults and children.* New York, Macmillan, 1936. 219 p.
2. Arey, Leslie B. *Developmental anatomy.* Philadelphia, Saunders, 1934. 593 p.
3. Arthur, Grace. *A point scale of performance tests. I. Clinical manual.* New York, Commonwealth Fund, 1930. 82 p.
4. Bronner, Augusta F., Healy, Wm., Lowe, Gladys M., and Shimberg, Myra E. *A manual of individual mental tests and testing.* Boston, Little, Brown, 1927. 287 p. (Judge Baker Foundation Publication No. 4).
5. Bühler, Charlotte. *The first year of life.* New York, Day, 1930. 281 p.
6. ———. *The child and his family.* New York, Harpers, 1939. 187 p.
7. Buros, Oscar Krisen. *The 1938 mental measurements yearbook.* New Brunswick, Rutgers Univ. Press, 1938. 415 p.
8. Calkins, L. A., Irvine, J. H., and Horsley, G. W. Variations in the length of labor. *Amer. J. Obst. & Gyn.*, 1930, 19:294-297, 580-582.
9. Carter, Jerry W., Jr. A case of reactional dissociation (Hysterical paralysis). *Amer. J. Orthopsychiat.*, 1937, 7:219-224.
10. Cole, H. N., Usilton, L. J., Moore, J. E., O'Leary, P. A., Stokes, J. E., Wile, U. J., Parran, T., Jr., and Von-

derlehr, R. A. Cooperative clinical studies in the treatment of syphilis: Syphilis in pregnancy. *J. Amer. Med. Assn.*, 1936, 106:464.

11. DeLee, J. B. *The principles and practice of obstetrics.* Philadelphia, Saunders, 1934. 1165 p.
12. Doll, Edgar A., Phelps, Winthrop N., and Melcher, Ruth T. *Mental deficiency due to birth injury.* New York, Macmillan, 1932. 289 p.
13. ———. Behavioral consequences of cerebral birth lesions. *Amer. J. Obst. & Gyn.*, 1936, 31:866.
14. ———. *The Vineland social maturity scale.* Vineland, N. J., The Training School, 1936. No. 3, 30 p.
15. Exner, M. J. Syphilis in pregnancy. *J. Amer. Med. Assn.*, 1936, 106:488.
16. Foster, Josephine. Play activities of children in the first six grades. *Child Develpm.*, 1930, 1:248-254.
17. Garrett, Harry E., and Schneck, Matthew R. *Psychological tests, methods and results.* New York, Harpers, 1933. 235 p.
18. Gesell, Arnold. *Mental growth of the pre-school child.* New York, Macmillan, 1925. 447 p.
19. ———. *Infancy and human growth.* New York, Macmillan, 1928. 418 p.
20. ———, and Thompson, H. *The psychology of early growth.* New York, Macmillan, 1938. 290 p.
21. Gilbert, M. S. *Biograpry of the unborn.* Baltimore, Williams & Wilkins, 1938. 132 p.
22. Goodenough, Florence L. *Measurement of intelligence by drawings.* New York, World Book Co., 1926. 177 p.
23. Griffith, J. P. Crozier, and Mitchell, A. Graeme. *The diseases of infants and children.* Philadelphia, Saunders, 1933. 1155 p.
24. Hess, Julius H., Mohr, George J., and Bartelme, Phyllis F. *The physical and mental growth of prematurely born children.* Chicago, Univ. of Chicago Press, 1934. 449 p.
25. Hildreth, Gertrude H. *A bibliography of mental tests and rating scales.* New York, Psychological Corporation, 1933.

242 p.

26. Kanner, Leo. *Child psychiatry.* Springfield, Ill., Thomas, 1935. 527 p.
27. Kantor, J. R. *A survey of the science of psychology.* Bloomington, Ind., Principia Press, 1933. 564 p.
28. Kent, Grace H. *Oral test for emergency use in clinics.* Baltimore, Williams & Wilkins, 1932. 50 p. (Mental Measurements Monogr. No. 9).
29. ———. Use and abuse of mental tests in clinical diagnosis. *Psychol. Rec.,* 1938, 2:391-400.
30. Lehman, Harvey C., and Witty, Paul A. *The psychology of play activities.* New York, Barnes, 1927. 242 p.
31. ———. A study of play in relation to intelligence. *J. Appl. Psychol.,* 1928, 12:369-397.
32. Lord, Elizabeth E. *Children handicapped by cerebral palsy.* New York, Commonwealth Fund, 1937. 120 p.
33. Louttit, C. M. *Clinical psychology.* New York, Harpers, 1936 . 695 p.
34. ———, and Carter, Jerry W., Jr. *The psychodiagnostic blank.* Ind. Univ. Psychol. Clinics, 1939. Pub. Ser. II, No. 7. 12 p.
35. ———. The nature of clinical psychology. *Psychol. Bull.,* 1939, 36: 361-389.
36. McLean, S., and Fales, H. L. *Scientific nutrition in infancy and early childhood.* Philadelphia, Lea & Febiger, 1925. 404 p.
37. Mitrano, Anthony J. The clinical interpretation of psychometric data. *Proc. Amer. Assn. Ment. Def.,* 1938, 43:156-160.
38. Morse, J. L. *Clinical pediatrics.* Philadelphia, Saunders, 1929. 848 p.
39. Pintner, R., and Patterson, Donald. *A scale of performance tests.* New York, Appleton-Century, 1917. 218 p.
40. Porteus, Stanley D. *The maze test and mental differences.* Vineland, N. J., Smith Publ. Co., 1933. 219 p.
41. Rogers, Carl R. *The clinical treatment of the problem child* Boston, Houghton Mifflin, 1939. 393 p.

42. Shirley, Mary M. *The first two years. Vol. I, Postural and locomotor development.* Minneapolis, Univ. Minnesota Press, 1931. 227 p.
43. Stander, H. J. *Williams obstetrics.* New York, Appleton-Century, 1936. 1269 p.
44. Stoddard, George D., and Wellman, Beth L. *Child psychology.* New York, Macmillan, 1934. 419 p.
45. Terman, Louis M. *The measurement of intelligence.* Boston, Houghton Mifflin, 1916. 362 p.
46. ———, et. al. *Genetic studies of genius: Vol. I, Mental and physical traits of a thousand gifted children.* Stanford University, Calif., Stanford Univ. Press, 1925. 648 p.
47. ———, and Merrill, Maud A. *Measuring intelligence.* New York, Houghton Mifflin, 1937. 461 p.
48. van Alstyne, Dorothy. *Play behavior and choice of play materials of pre-school children.* Chicago, Univ. Chicago Press, 1932. 104 p.
49. von Reuss, A. R. *The diseases of the newborn.* New York, Wood, 1929. 626 p.
50. White House Conference on Child Health and Protection. Sec. I B. Medical Service. Subcommittee on Factors and Causes of Fetal, Newborn, and Maternal Morbidity and Mortality. *Fetal, newborn, and maternal morbidity and mortality.* New York, Appleton-Century, 1933. 486 p.